Northwood Hills Dental Practice

NEW PATIENT REGISTRATION

Welcome & thank you for selecting us

Mr/Mrs/Miss/Ms **Date of birth:**

Surname: **Occupation**

Forename:

Full postal address: **Postcode:**

Town: **E-mail:**

Tel (home): **Tel (mobile):**

National Insurance number:

NHS number *(if known):*

(N.b Information provided will never be passed to third parties except in matters relating to your care and treatment. Mobile number provided to be used for text message appointment reminders)

Exemption from dental charges

Are you currently exempt from payment of dental charges? If unsure- leave blank ***YES / NO***
If 'Yes' please be prepared to provide details (you will be asked to provide proof)

Ethnicity

- ❑ *White British*
- ❑ *White Irish*
- ❑ *Other White background*
- ❑ *White & Black Caribbean*
- ❑ *White & Asian*
- ❑ *Other Mixed*
- ❑ *White & black African*
- ❑ *Asian/Asian British Indian*
- ❑ *Asian/Asian British Pakistani*
- ❑ *Asian/Asian Bangladeshi*
- ❑ *Other Asian background*
- ❑ *Black/Black British Caribbean*
- ❑ *Black/Black British African*
- ❑ *Other black background*
- ❑ *Chinese*
- ❑ *Any other ethnic group*
- ❑ *Decline to state*

Further information

Approx date of last visit to a dentist (Month/year) ....

Please tick below any areas in particular you would like further information

- ☐ Crowns/bridges or veneers
- ☐ Airflow stain removal
- ☐ Seeing the Hygienist
- ☐ Teeth whitening options
- ☐ Reducing tooth sensitivity
- ☐ Denture services
- ☐ Improving gum health
- ☐ Improving bad breath
- ☐ Improving the look of my smile
- ☐ Implants
- ☐ Sports Gumshields
- ☐ Other - please specify

Please be aware of our policy requiring at least 48 hours notice for cancellation of any appointment

Medical History (New Patient registration)

Certain medical conditions can affect dental treatment and vice-versa.
Please complete this form by ticking the appropriate boxes and answering the questions.

All details will be strictly confidential

Do you have or have you ever suffered from:

Any heart complaint / heart surgery / stroke / pacemaker fitted?	YES / NO
Rheumatic fever?	YES / NO
High Blood Pressure?	YES / NO
Diabetes?	YES / NO
Excessive bleeding / bruising?	YES / NO
Chronic bronchitis /asthma / emphysema?	YES / NO
Epilepsy or fainting attacks?	YES / NO
Hepatitis / liver disease / jaundice / kidney disease?	YES / NO
Any other serious illness?	YES / NO
Do you carry a MEDICAL WARNING ALERT CARD?	YES / NO
Are you ALLERGIC to any FOODS,MEDICINES,SUBSTANCES OR LATEX? *List below*	YES / NO
At present taking any medicine or tablets? *List below*	YES / NO
Pregnant?	YES / NO
In the past two years have you undergone any operations?	YES / NO
Or been treated with Hydrocortisone or corticosteroids?	YES / NO
Have you ever had a joint replacement operation / organ transplant?	YES / NO
Is there any chance you may have contracted HIV, hepatitis, CJD?	YES / NO
Do you chew Tobacco, Betal nut, Gutkha, Paan or Sopari	YES / NO
If you smoke, what is your average per week?	....
If you drink what is your average weekly consumption of alcohol?	....

If 'yes' to any questions, please supply details in 'Notes' below. Include medication.

Name and Address of your Doctor?

....
....
....

Notes:..
....
....
....

If you are not sure of any of the questions, or if your medical circumstances change, please let us know

Patient's Signature:.. **Date:**........................

Updated: ....

Thank you

"Dedicated to provide the best treatment possible in a friendly and caring environment"